~~1021 CARE MANAGEMENT~~

~~REVISION DATE: MM/DD/YYYY~~
~~EFFECTIVE DATE: 7/20/2022~~
~~REFERENCES: A.R.S. §§ 13-3994, 31-501, 36-551, 38-211; 42 CFR 438.100(a)(1), 438.100(b)(2)(vi), 438.114(a), 438.208(b)(2)(ii) and (iii), 457.1220, 457.1230(c); 45 CFR Part 160 and 164; AdSS Medical Manual Policy 310-HH~~

~~PURPOSE~~

~~This policy sets forth roles and responsibilities of the Administrative Services Subcontractors (AdSS) for provision of Care Management services and collaboration with the Division of Developmental Disabilities (Division) to improve health outcomes for members with high risk and/or complex care needs who require intensive physical, and/or behavioral health support services.~~

~~DEFINITIONS~~

~~1. "Advance Care Planning" means a part of the End-of-Life care concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the member to:~~

~~a. Educate the member/guardian/health care decision maker about the member's illness and the health care options that are available to them.~~

~~b. Develop a written plan of care that identifies the member's choices for treatment.~~

~~c. Share the member's wishes with family, friends, and his or her physicians.~~

~~2. "Arizona State Hospital (AzSH)" means the state hospital providing long-term inpatient psychiatric care to Arizonans with mental illnesses who are under court order for treatment.~~

~~3. "Care Management" means a group of activities performed by the Division to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health outcomes. Distinct from Case Management, Care Management does not include the day-to-day duties of service delivery.~~

~~4. "Conditional Release Plan (CRP)" means a supervised treatment~~

~~plan. If the psychiatric security review board finds that the person still suffers from a mental disease or defect or that the mental disease or defect is in stable remission, but the person is no longer dangerous, the board must order the person's conditional release. The person must remain under the board's jurisdiction. The board in conjunction with the state mental health facility and behavioral health community providers must specify the conditions of the person's release. The board must continue to monitor and supervise a person who is released conditionally. Before the conditional release of a person, a supervised treatment plan must be in place, including the necessary funding to implement the plan as outlined in A.R.S. § 13-3994.~~

~~5. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to~~

~~result in:~~

~~a. Placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;~~

~~b. Serious impairment to bodily functions;~~

~~c. Serious dysfunction of any bodily organ or part [42 CFR 438.114(a)]; or~~

~~d. Serious physical harm to another individual (for behavioral health conditions).~~

~~6. "End-of-Life Care" means a concept of care, for the duration of the member's life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex, or terminal illness.~~

~~7. "Informal Support" means non-billable services provided to a member by a family member, friend, or volunteer to assist or perform functions such as, but not limited to:~~

~~a. Housekeeping,~~

~~b. Personal care,~~

~~c. Food preparation,~~

~~d. Shopping,~~

~~e. Pet care, or~~

~~f. Non-medical comfort measures.~~

~~8. "Medication Assisted Treatment (MAT)" means the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.~~

~~9. "Planning Team" is a group of individuals that shall include the member, Responsible Person (when applicable), Support Coordinator, and a representative from the agency for the member's living in a licensed setting and with the member's consent, their Health Care Decision Maker, Designated Representative and any individuals important in the member's life, including but not limited to extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents~~

~~from other service systems. The size, scope, and intensity of involvement of the team members are determined by the objectives of the planning team to best meet the needs and individual goals of the member.~~

~~10. "Psychiatric Security Review Board (PSRB)" is the psychiatric security review board is established consisting of the following members who are appointed by the governor pursuant to A.R.S. § 38-211 as outlined in A.R.S. § 31-501 experienced in the criminal justice system:~~

~~a. One psychiatrist~~

~~b. One psychologist~~

~~c. One person who is experienced in parole, community supervision, or probation procedures~~

~~d. One person who is from the general public~~

~~e. One person who is either a psychologist or a psychiatrist.~~

~~11. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental~~

~~disability who is a client or an applicant for whom no guardian has been appointed. A.R.S. § 36-551.~~

~~12. "Service Plan (SP)" means a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.~~

~~13. "Special Health Care Needs (SHCN)" means serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a primary care provider.~~

~~14. "Support Coordination" means a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to~~

promote quality, cost-effective outcomes.

POLICY

The AdSS shall provide Care Management for members with high risk and/or complex special health care needs with the goal of meeting member biopsychosocial needs and improving health outcomes.

AdSS Care Managers work closely with the Division's Support Coordinator and the Planning Team to ensure the most appropriate plan and services are in place for members who are medically complex and require intensive physical, and/or behavioral health support services. Care management services are enlisted when the Support Coordinator requires assistance to resolve a member's care need (whether it is physical or behavioral health related) when any of the following are involved: the Division function areas, covered services provided through the AdSS, and/or the provider network.

A. CARE MANAGEMENT

1. Care Management services provided by the AdSS shall be designed to be short-term and time limited.

2. The AdSS shall ensure its Care Management program does the following:

a. Resolve barriers and/or challenges to meeting individualized member needs identified in the individualized service plan including continuity and sustainability of care and treatment;

b. Identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes and support wellness and quality of life;

c. Recognizes the importance and responsibility of engagement in treatment and care including receipt of information, education, training, technical assistance and access to web based, digital and electronic supports, as appropriate to promote their own health;

d. Work collaboratively, as appropriate, with the Division, Tribal Regional Behavioral Health Authorities (TRBHAs), and treatment providers throughout the continuum of services to support access to care, treatment and supports

~~to resolve an unmet care need;~~

~~e. Ensure that services are provided timely and cost effectively;~~

~~f. Ensure continuity of care which reflects integration of services that preserves:~~

~~i. Each member's privacy in accordance with the privacy requirements including, but not limited to, as those specified in 45 CFR Part 160 and 164, Arizona statutes and regulations, and to the extent applicable in 42 CFR 457.1220, 42 CFR 438.100(a)(1), and 42 CFR 438.100(b)(2)(vi);~~

~~ii. Member choice in selecting a PCP and/or a behavioral health provider who is formally designated as having primary responsibility for coordinating the member's overall health care;~~

~~iii. Access to care that is appropriate to their individual needs by providing continuity and coordination of~~

~~care of both in network and out of network services as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(1);~~

~~g. Ensure each member receiving care coordination has an individual or entity formally designated as primarily responsible for coordinating services for the member, such as the care manager, Division Support Coordinator, or provider case manager. The member/responsible person shall be provided information on how to contact their designated person or entity as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(1);~~

~~h. The AdSS tribal coordinator facilitates the promotion of services and programs to improve the quality and accessibility of health care to enrolled American/Alaskan Indian members. The tribal coordinator collaborates with Care Management to ensure communication with all tribal programs are actively engaged in the member's care coordination process.~~

~~**B. REFERRAL**~~

~~1. The AdSS shall accept referrals from the Division's Support Coordination staff of members who fit the selection criteria to receive care management, and who elect to utilize this resource.~~

~~2. Referrals for Care Management made by the Division Support Coordinator are made when initial efforts to resolve an unmet care need using the Division or AdSS escalation process is unsuccessful.~~

~~3. For members who are enrolled in the Tribal Health Program (THP), the Division coordinates covered services with FFS providers.~~

~~4. The Division is responsible for coordinating covered services for members enrolled with the AdSS.~~

~~C. **ELIGIBILITY**~~

~~The AdSS shall have policies and procedures in place to identify members eligible for Care Management. The AdSS utilizes the following criteria to identify and refer members to Care Management~~

~~services:~~

1. ~~Frequent use of the Emergency Department instead of seeing providers for ongoing issues (4 or more occurrences within the past 6 months);~~

2. ~~Multiple physical and/or behavioral health hospitalizations (3 or more inpatient or readmissions within the past 6 months);~~

3. ~~Discharged from an inpatient or skilled facility and requires coordination of post-acute services;~~

4. ~~Missed 3 or more physical and/or behavioral health appointments within the past 3 months;~~

5. ~~Having difficulty obtaining medical benefits or referrals ordered by providers;~~

6. ~~Diagnosed with heart failure, diabetes, asthma, chronic obstructive pulmonary disease, or depression and requires assistance with management of the condition;~~

7. ~~In the process of receiving a transplant, and/or up to one-year~~

~~post-transplant;~~

~~8. Diagnosed with Human Immunodeficiency Virus (HIV);~~

~~9. Pregnant;~~

~~10. Diagnosed with a behavioral health disorder, the condition is not stable and requires assistance with management of the condition;~~

~~11. Need exclusive provider restriction for overutilization of drugs with abuse potential;~~

~~12. Needs referral to or is currently receiving medication assisted treatment (MAT) for opioid use;~~

~~13. Has social determinants of health needs that are impacting member's ability to obtain the appropriate care (e.g., basic needs not being met, safety issues in home environment);~~

~~14. Survivor of sex trafficking;~~

~~15. Recently been incarcerated or is transitioning out of jail or prison within the next 30 days;~~

~~16. Has out-of-state needs;~~

~~17. Requires assistance with Tribal Nations or providers;~~

~~18. Is a child with one or more of the following:~~

~~a. Newborn with neonatal abstinence syndrome or maternal drug exposure,~~

~~b. Child and Adolescent Level of Care Utilization System (CALOCUS) level 4 or higher,~~

~~c. Serious emotional disturbance,~~

~~d. Possible Children's Rehabilitation Services (CRS) condition, or~~

~~e. Recently removed from his/her home and placed in foster care.~~

~~D. REQUIREMENTS~~

~~1. Care Managers:~~

~~a. Work closely with the Support Coordinator and the Planning Team to ensure the most appropriate supports are in place for the member;~~

~~b. Identify and manage clinical interventions or alternative treatments to reduce risk, cost, and help achieve improved health outcomes;~~

~~c. Coordinate and ensure access to physical and behavioral health care needs across the continuum based on early identification of health risk factors or special health care needs consistent with the individualized service plan including:~~

~~i. Coordinating the services for members between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(2)(i);~~

~~ii. Coordinating covered services with the services the member receives from another entity and/or FFS provider as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(2)(ii) and (iii);~~

iii. Coordinating covered services and supports with community and social services;

iv. Ensuring members receive End-of-Life Care and Advance Care Planning as specified in AdSS Medical Manual Policy 310-HH;

v. Establishing timely and confidential communication of clinical information among providers. This includes:

- The coordination of member care among the PCP, AdSS, and TRBHA;
- Working with the PCP to communicate all known primary diagnoses, comorbidities, and changes in condition to the Division and/or FFS and TRBHA when the PCP becomes aware of the Division, or TRBHA involvement in care.

2. Care Managers activities include identifying, managing, and monitoring clinical interventions or alternative treatments to:

a. Reduce risk,

~~b. Improve access to care and services,~~

~~c. Reduce gaps in care, and~~

~~d. Facilitate safe transitions in care.~~

~~3. Care Managers provide support to Support Coordinators by assisting members to ensure continuity of care and resolve barriers to meeting identified needs in the individualized service plan, including access to identified services and supports, and maintaining continuity of care, engagement of the member/responsible person in treatment.~~

~~4. The Care Manager communicates with the Support Coordinator and other team members on an ongoing basis to develop a plan to resolving barriers/challenges to implementing the individualized service plan including:~~

~~a. Resolving coordination issues with the care team, treatment/ services providers and allied supports.~~

~~b. Establishing and maintaining treatment relationships that foster consistent and timely interventions.~~

~~c. Coordinating with primary care provider/specialty care provider(s) and medical/behavioral treatment teams.~~

~~d. Ensuring timely access to treatment services, allied supports and/or evidence-based practices to enhance the health, wellness and quality of life of the member while reducing the need for hospitalization and other costly treatments.~~

~~e. Supporting transitions from inpatient or institutional setting to the community.~~

~~f. Engaging members/responsible person in treatment through:~~

~~i. Individualized targeted interventions designed to improve and sustain member engagement in treatment.~~

~~ii. Collaboration on actions to be taken by the member and/or responsible person.~~

~~g. Health education, resources and support tailored to the~~

~~member's needs, including but not limited to:~~

~~i. Working with the care team, treatment/ services providers and allied supports;~~

~~ii. Establishing and maintaining treatment relationships that foster consistent and timely interventions;~~

~~iii. Understanding the member role in health and wellness;~~

~~iv. Healthy living and wellness programs;~~

~~v. The Care Manager shall provide ongoing communication and technical assistance as needed, informing the Support Coordinator of any substantial developments or changes that occur in between Planning Team meetings and/or modifications/updates to the care plan.~~

~~5. Care Management works collaboratively with Support Coordination and the Planning Team to meet the needs of members who:~~

~~a. Are enrolled in Justice Reach In Program Care management facilitates the transition of members with chronic and/or complex care needs out of jails and prisons and into communities.~~

~~b. Have Behavioral health complexities - Care Management ensures that behavioral health needs are met for members with mental health disorders, substance use disorders (SUDs), and who are designated to have a Serious Mental Illness (SMI).~~

~~c. Are discharged from the Arizona State Hospital - Care Management coordinates with the Division Behavioral Health Complex Care Specialist and Support Coordinator for members on Conditional Release from the AzSH consistent with the Conditional Release Plan (CRP) issued by the Psychiatric Security Review Board (PSRB) to facilitate discharge. The AdSS shall coordinate with the Division's Behavioral Health Complex Care Specialist and Support Coordinator to ensure:~~

~~i. Coordination with AzSH for discharge planning, including ensuring the member with diabetes has appropriate diabetic monitoring equipment and supplies, and has been educated and trained to the use prior to discharge;~~

~~ii. Participation in the development and implementation of the CRP;~~

~~iii. Participation in the modification of an existing or the development of a new Planning Document that complies with the CRP;~~

~~iv. Member outreach and engagement at least once per month to assist the PSRB in evaluating compliance~~ Member outreach and engagement at least once per month to assist the PSRB in evaluating compliance with the approved CRP;

~~v. Attendance in outpatient staffing at least once per month either telephonically or face-to-face;~~

vi. Coordination of care with the member's treatment team, assigned Support Coordinator, and providers of both physical and behavioral health services to implement the Planning Document and the CRP;

vii. Routine delivery of comprehensive status reporting to the PSRB and AHCCCS MM;

viii. Attendance in a monthly conference call with the AHCCCS Division of Health Care Services for any members residing in AzSH that meet the criteria for PSRB;

ix. Assistance with care coordination for members who are awaiting placement into AzSH by communicating with the member/responsible person, Support Coordinator, facilities, providers, and AzSH;

d. If a member violates any term of his or her CRP, the Division must immediately notify the PSRB and provide a copy to the AzSH.

e. The AdSS shall follow all obligations, including those stated above, applicable to it as set forth as specified in A.R.S. § 13-3994.

f. Are enrolled in the High Needs High Cost Program – Care Management works to reduce the high utilization of the Emergency Department for non-emergency or preventable emergency department care to facilitate the right care, at the right time, in the most appropriate setting.

g. Have multiple complaints regarding services or the AHCCCS Program. This includes members who do not otherwise meet the Division criteria for care management, as well as members who contact governmental entities for assistance, including AHCCCS.

E. MONITORING AND OVERSIGHT

The AdSS will meet with the Division Health Care Services (HCS) quarterly to review the AdSS Medical Management Committee minutes, reports with data analysis and action plans, over- and under-utilization, outliers, and opportunities for performance improvement.

~~The AdSS shall identify, track and report members who utilize Emergency Department (ED) services inappropriately four or more times within a six-month period. Interventions shall be implemented to educate the member/responsible person on appropriate use of ED and divert members to the right care in the appropriate place of service.~~

~~The AdSS shall submit AMPM 1021-C and AMPM 1021-B to the division monthly.~~

~~Annually the Division will perform an Operational Review of the AdSS utilization process.~~

~~Signature of Chief Medical Officer:~~

1021 CARE MANAGEMENT

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EFFECTIVE DATE: 7/20/2022
REFERENCES: A.R.S. §§ 13-3994; A.R.S. §§ 31-501; A.R.S. §§ 36-551; A.R.S. §§ 38-211; 42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(vi); 42 CFR 438.208(b)(2)(ii) and (iii); 42 CFR 438.208(b)(2)(iv);

42 CFR 457.1220; 42 CFR 457.1230(c); 45 CFR Part 160 and 164; AMPM 310-HH; AMPM 520; AMPM 570; AMPM 580; AMPM 940; AMPM 1010; AMPM 1021; AMPM 1620; ACOM 438.

PURPOSE

This policy sets forth roles and responsibilities of the Administrative Services Subcontractors (AdSS) for provision of Care Management services and collaboration with the Division of Developmental Disabilities (Division) to improve health outcomes for Members eligible for ALTCS who may or may not have a chronic disease but have physical or behavioral health needs or risks that require immediate AdSS intervention.

DEFINITIONS

1. "Advance Care Planning" means a part of the End-of-Life Care concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the Member to:
    a. Educate the Member about their illness and the health care options that are available to them;
    b. Share the Member's wishes with family, friends, and his or

her physicians.

c. Develop a written plan of care that identifies the Member's choices for treatment;

2. "Arizona State Hospital" or "ASH" means the state hospital providing long-term inpatient psychiatric care to Arizonans with mental illnesses who are under court order for treatment.

3. "Care Management" means a group of activities performed by the Division to identify and manage clinical interventions or alternative treatments for identified Members to reduce risk, cost, and help achieve better health outcomes. Distinct from Support Coordination, Care Management does not include the day- to-day duties of service delivery.

4. "Care Manager" means someone who provides Care Management services.

5. "End-of-Life Care" means a concept of care, for the duration of the Member's life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve

quality of life for a Member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex, or terminal illness.

6. "Informal Supports" means non-billable services provided to a Member by a family member, friend, or volunteer to assist or perform functions such as:
   a. Housekeeping,
   b. Personal care,
   c. Food preparation,
   d. Shopping,
   e. Pet care, or
   f. Non-medical comfort measures.

7. "Medication Assisted Treatment" or "MAT" means the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.

8. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

9. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the Services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such Services and supports.

10. "Planning Team" means a group of people including the Member; Responsible Person; the Support Coordinator; other State of Arizona Department of Economic Security staff; as necessary; and any person selected by the Member; Responsible Person; or the Department.

11. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed.

12. "Social Determinants of Health" or "SDOH" means the social, environmental, and economic factors that can influence health

status and have an impact on health outcomes.

13. "Special Health Care Needs (SHCN)" means serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by Members generally that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a Primary Care Provider (PCP).

14. "Support Coordination" means a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

15. "Support Coordinator" means the same as "case manager" under A.R.S. § 36-551.

POLICY

A. COMPONENTS OF CARE MANAGEMENT

1. The AdSS shall have in place a Care Management process with

the primary purpose of coordinating care and assisting in accessing resources for Members with multiple or complex conditions and who require intensive physical, or behavioral health support services.

2. The AdSS shall have multiple methods for referring a Member to Care Management, including referrals from the Member or Responsible Person, internal sources, provider or the Division.

3. The AdSS shall provide Care Management that is designed to be short-term and time-limited in nature.

4. The AdSS shall require the following Care Management services:

   a. Assistance in making and keeping needed physical or behavioral health appointments;

   b. Following up and explaining hospital discharge instructions;

   c. Health coaching and referrals related to the Member's immediate needs;

   d. Primary Care Provider (PCP) reconnection; and

e. Offering other resources or materials related to wellness, lifestyle, and prevention.

5. The AdSS shall provide care coordination to ensure Members receive the necessary services to prevent or reduce an adverse health outcome.

6. The AdSS shall ensure that clinical resources and assessment tools utilized are evidenced-based.

7. Care Managers shall establish a process to ensure coordination of Member physical and behavioral health care needs across the continuum, based on early identification of health risk factors or Special Health Care Needs (SHCN) consistent with the Planning Document.

8. The AdSS shall ensure the coordination ensures provision of physical and behavioral services in any setting that meets the Member's needs in the most cost-effective manner available.

9. Care Managers shall be expected to have direct contact with Members for the purpose of providing information and

coordinating care.

10. The AdSS Care Management program shall automatically document the staff member's name and ID and the date and time the action or contact with the Member occurred.

11. The AdSS Care Management program shall also provide automatic prompts and reminders to follow-up with the Member as specified in the Member's care plan.

12. The AdSS shall provide Care Management at the contractor level as an administrative function. If the AdSS intends to delegate a portion of the Care Management functions, prior approval by the Division is required.

13. The AdSS shall ensure the Care Managers are not performing the day-to-day duties of the Division Support Coordinator, the provider case manager, or the TRBHA case manager.

14. Care Managers shall work closely with case managers referred to in this section, to ensure the most appropriate service plan and services for Members.

15. The AdSS shall develop Member selection criteria for the Care Management model to determine the service intensity or targeted interventions a Member may require to help achieve improved health outcomes and reduce risk and cost.

16. The AdSS shall integrate data from medical and behavioral health claims or encounters, pharmacy claims, laboratory results, Health Risk Assessments (HRA)s, Electronic Medical Records (EMRs), health services programs within the organization, or other advanced data sources to develop the selection criteria.

17. The AdSS shall stratify Members for Care Management for targeted interventions, on at least an annual basis.

B. CARE MANAGER RESPONSIBILITIES

1. Care Managers shall comprehensively assess the Member and develop and implement a care plan that has the following:

a. Initial assessment of Members:

i. Health status;

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ii. Physical and behavioral health history, including medications and cognitive function;

iii. Activities of daily living;

iv. Social Determinants of Health (SDOH).

b. Life planning activities, including wills, living wills, advance directives, health care powers of attorney, End-of-Life Care and Advance Care Planning.

c. Evaluation of:

i. Cultural and linguistic needs and preferences;

ii. Visual and hearing needs and preferences;

iii. Caregiver resources; and

iv. Availability of services, including community resources.

d. Development of a Care Management plan, including self-management tools, prioritized goals that consider Member and caregiver preferences and desired level of involvement;

e. Identification of barriers;

f. Facilitation of referrals and a follow-up process to determine if Members act on referrals made;

g. Development of a schedule for follow-up and communication with the Member;

h. A process and timeframe for monitoring the effectiveness of Care Management.

2. Care Managers shall work with the Support Coordinator, the provider case manager, AdSS tribal liaison, the Primary Care Physician (PCP) or specialist(s) to coordinate and address Member needs within 30 days after the member has been determined eligible to receive Care Management.

3. Care Managers shall continuously document interventions and changes in the plan of care.

C. AdSS RESPONSIBILITIES

1. The AdSS shall establish policies and procedures that reflect integration of services to ensure continuity of care by:

a. Ensuring that in the process of coordinating care, each Member's privacy is protected in accordance with the privacy requirements including those specified in 45 CFR Part 160 and 164, Arizona statutes and regulations, and to the extent applicable in 42 CFR 457.1220, 42 CFR 438.100(a)(1), and 42 CFR 438.100(b)(2)(vi);

b. Allowing Member choice in selecting a PCP, TRBHA or a behavioral health provider who is formally designated as having primary responsibility for coordinating the Member's overall health care;

c. Ensuring access to care that is appropriate to their individual needs as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(1);

d. Ensuring each Member receiving care coordination has an individual or entity that is formally designated as primarily responsible for coordinating services for the Member, such as the Division Support Coordinator, the provider case

manager, or TRBHA case manager;

e. Ensuring the Care Manager provides the Responsible Person with information on how to contact their designated person or entity as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(1);

f. Specifying under what circumstances services are coordinated by the AdSS, including the methods for coordination and specific documentation of these processes;

g. Coordinating the services for Members between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(2)(i);

h. Coordinating covered services with the services the Member receives from another entity or FFS provider as specified in 42 CFR 457.1230(c) and 42 CFR

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438.208(b)(2)(ii) and (iii);

i. Coordinating covered services with community and Informal Supports that are generally available through another entity or FFS provider in the Division's service area, as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(2)(iv);

j. Ensuring Members receive End-of-Life Care and Advance Care Planning;

k. Ensuring Care Managers establish timely and confidential communication of data and clinical information among providers that includes:

i. The coordination of Member care among the PCP, AdSS, and tribal entities;

ii. Working with the PCP to communicate all known primary diagnoses, comorbidities, and changes in condition to the Division or FFS provider and Tribal provider to include TRBHA when the PCP

becomes aware of the Division, or TRBHA involvement in care.

l. Ensuring that the AdSS is providing pertinent diagnoses and changes in condition to the PCP:

i. No later than 30 days from change in medication or diagnosis, or

ii. No later than 7 days of hospitalization.

m. Facilitating this communication exchange as needed and establish monitoring activities such as record review to ensure that the exchange occurs;

n. Ensuring Care Managers provide consultation to a Member's inpatient and outpatient treatment team and directly engages the Member as part of AdSS Care Management;

o. Ensuring individuals admitted to a hospital who are identified as in need of behavioral health services, are responded to as specified below:

i. Upon notification of an individual who is not currently receiving behavioral health services, the AdSS shall ensure a referral is made to a provider agency within 24 hours.

p. Ensuring that provider agencies attempt to initiate services with the individual within 24 hours of referral and that the provider agency schedules additional appointments and services with the individual prior to discharge from the hospital;

q. Ensuring coordination, transition, and discharge planning activities are completed consistent with providers orders to ensure cost effectiveness and quality of care for Members already receiving behavioral health services;

r. Ensuring policies reflect care coordination for Members presenting for care outside of the AdSS' provider network;

s. Identifying and coordinating care for Members with Substance Use Disorder (SUD) and ensure access to

appropriate services such as Medication Assisted Treatment (MAT) and peer support services;

2. The AdSS shall develop policies and implement procedures for Members with SHCN, as specified in the contract with the Division and AMPM Policy 520, including:
   a. Identifying Members with SHCN;
   b. Ensuring an assessment by an appropriate health care professional for ongoing needs of each Member;
   c. Ensuring adequate care coordination among providers or TRBHAs;
   d. Ensuring a mechanism to allow direct access to a specialist as appropriate for the Member's condition and identified needs (e.g., a standing referral or an approved number of visits); and
   e. Additional care coordination activities based on the needs of the Member.

3. The AdSS shall implement measures to ensure that the Responsible Person involved in Care Management:
   a. Is informed of particular health care conditions that require follow-up;
   b. Receives, as appropriate, training in self-care and other measures they may take to promote their own health; and
   c. Is informed of their responsibility to comply with prescribed treatments or regimens.
4. The AdSS Care Management shall focus on achieving Member wellness and autonomy through:
   a. Advocacy,
   b. Communication,
   c. Education,
   d. Identification of service resources, and
   e. Service facilitation.
5. The Care Manager shall also assist the Responsible Person in identifying appropriate providers, TRBHAs, or other FFS

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873
874 providers, and facilities throughout the continuum of services.
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876 6. The Care Manager shall ensure that available resources are
877 being used in a timely and cost-effective manner in order to
878 obtain optimum value for both the Member and the AdSS.

879 7. The AdSS shall proactively provide care coordination for
880 Members who have multiple complaints regarding services or the
881 AHCCCS Program. This includes Members who do not otherwise
882 meet the Division criteria for Care Management, as well as
883 Members who contact governmental entities for assistance,
884 including AHCCCS.

885 8. The AdSS shall report its monitoring of Members awaiting
886 admission and those Members who are discharge-ready from
887 Arizona State Hospital (ASH) utilizing the Arizona State Hospital
888 Admission and Discharge Deliverable Template.

889 9. The AdSS shall demonstrate proactive care coordination efforts
890 for all Members awaiting admission to, or discharge from ASH.

891 10. The AdSS shall coordinate with ASH for discharge planning,

including ensuring the Member with diabetes has appropriate diabetic monitoring equipment and supplies, and has been educated and trained to the use prior to discharge.

11. The AdSS shall not limit discharge coordination and placement activities based on pending eligibility for ALTCS.

12. The AdSS shall submit the following, in the case that a Member has been awaiting admission to, or discharge from ASH for an excess of 90 days:

    a. A barrier analysis report to include findings, performance improvement activities and implementation plan, and

    b. A status report for each Member who is continuing to await admission or discharge as specified in the contract with the Division.

13. The AdSS shall arrange ongoing medically necessary nursing services consistent with providers orders to ensure cost effectiveness and quality of care in the event that a Member's mental status renders themself incapable or unwilling to manage

their medical condition and the Member has a skilled medical need.

14. The AdSS shall identify, track and report Members who utilize Emergency Department (ED) services inappropriately four or more times within a six-month period.

15. The AdSS shall implement interventions to educate the Responsible Person on appropriate use of ED and divert Members to the right care in the appropriate place of service.

16. The AdSS shall ensure Care Management interventions to educate Responsible Persons include:

    a. Outreach phone calls or visits,

    b. Educational letters,

    c. Behavioral health referrals,

    d. HNHC program referrals,

    e. Disease or chronic Care Management referrals,

    f. Exclusive pharmacy referrals, or

    g. Social Determinants of Health (SDOH) resources.

17. The AdSS shall submit AMPM Attachment 1021-A as specified in the contract with the Division, identifying the number of times the AdSS intervenes with Members utilizing the ED inappropriately.

18. The AdSS shall monitor the length of time Members remain in the ED while awaiting behavioral health placement or wrap-around services.

19. The AdSS shall coordinate care with the ED and the Member's treatment team to discharge the Member to the most appropriate placement or wrap-around services immediately upon notification that a Member who requires behavioral health placement or wrap-around services is in the ED.

20. The AdSS Chief Medical Officer shall be involved when Members experience a delay in discharge from institutional settings or the ED.

21. The AdSS shall submit the 24 Hours Post Medical Clearance ED Report utilizing Attachment B to the Division as specified in the contract with the Division.

22. The AdSS shall develop a plan specifying short-term and long-term strategies for improving care coordination and Care Management as specified in the MM Program workplan.

23. The AdSS shall develop an outcome measurement plan to track the progress of the strategies in the MM Program workplan.

24. The AdSS shall report the plan specifying the strategies for improving care coordination and the outcome measurement in the annual MM Program Plan, and submitted as specified in the contract with the Division, utilizing AMPM Policy 1010 Attachment A and Attachment B.

25. The AdSS tribal liaison shall facilitate the promotion of services and programs to improve the quality and accessibility of health care to enrolled American Indian and Alaskan Native Members.

26. The AdSS tribal liaison shall collaborate with Care Management to ensure communication with all tribal programs are actively engaged in the Member's care coordination process.

27. The AdSS shall meet with the Division HCS quarterly to review the AdSS Medical Management Committee minutes, reports with data analysis and action plans, over and under-utilization, outliers, and opportunities for performance improvement.

28. The AdSS shall coordinate with the Division's Behavioral Health Complex Care Specialist and Support Coordinator to provide assistance with care coordination for Members who are awaiting placement into ASH by communicating with the Responsible Person, Support Coordinator, facilities, providers, and ASH.

D. HIGH NEEDS/HIGH COST (HNHC) PROGRAM

1. The AdSS shall identify, implement, and monitor interventions for providing appropriate and timely care to Members with high needs or high costs who have physical or behavioral health needs.

2. The AdSS shall collaborate with the Division HCS to coordinate care for Members enrolled in the High Needs/High Costs (HNHC) program who have physical or behavioral health needs;

3. The AdSS shall participate in care coordination or interdisciplinary team meetings at least monthly, or more often, as needed, to affect change and if needed to discuss barriers and outcomes

4. The AdSS shall implement the following:

a. Planning interventions for addressing appropriate and timely care for the identified Members.

a. Specifying methodologies, inclusion criteria, interventions, and Member outcomes based on data analysis; and

b. Utilizing additional criteria if the AdSS determines it necessary.

5. The AdSS shall submit an overview of the HNHC program, which shall include the requirements in section (D), in the Medical Management (MM) Program Plan submission, AMPM Attachment 1010-A;

6. The AdSS shall submit counts of distinct Members that are considered to have high cost behavioral health needs based on criteria developed by the AdSS and approved by the Division;

7. The AdSS shall submit the High-Cost Behavioral Health Report on AMPM Attachment 1021-E as specified in the contract with the Division;

8. The AdSS Care Management program for HNHC Members shall incorporate a stratification approach to differentiate levels of Care Management provided based on factors such as:

a. The severity of the conditions,

b. Complexity of treatment coordination needs,

c. Presence of co-occurring substance use or mental health conditions,

d. Health or safety risks,

e. Inpatient or ED utilization,

f. Poly-Pharmacy,

g. Functional deficits, and

h. Involvement with other Member-serving systems.

9. The AdSS shall provide in their proposed stratification methodology the appropriate levels of Care Management necessary to ensure health, welfare and safety for Members and should consider such factors as:
    a. Caseload mix;
    b. Member acuity and coordination needs; and
    c. Care Manager qualifications, experience and responsibilities.

10. The AdSS shall ensure the Care Management Program for High Need/High Cost Members has prior approval of the Division. Material changes to a Division-approved Care Management Program must be approved in advance by the Division.

11. The AdSS shall develop and implement policies and procedures related to the AdSS Care Management Program for HNHC Members to ensure the active coordination of integrated physical and behavioral health services with Long Term Support Services (LTSS), in collaboration with the Support Coordinator for HNHC Members.

Signature of Chief Medical Officer: